

Hospital-Acquired Infection Incident Report Form

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| Reported By | <input type="text"/> |
| Date of Report | <input type="text"/> |
| Department/Unit | <input type="text"/> |
| Patient Identifier | <input type="text"/> |
| Date of Onset | <input type="text"/> |
| Type of Infection | <input type="text"/> |
| Site/Location of Infection | <input type="text"/> |
| | <input type="text"/> |
| Brief Description of Incident | <input type="text"/> |
| Identified Micro-organism (if known) | <input type="text"/> |
| | <input type="text"/> |
| Immediate Actions Taken | <input type="text"/> |
| | <input type="text"/> |
| Recommended Follow-up | <input type="text"/> |
| Reporter Signature | <input type="text"/> |